ATTACHMENT D PART 3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Ward, Myron		05967-084

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
8906 Ascot Ln, Apt 11, Laurel, Md. 20708	biennial	12/3/03

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
male	Black				

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/7/80	Washington, D.C.	Mae Daniels - Mother same (301) 669-9352

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
FCC Pet. Low	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	✓
✓	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities,etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G.U. SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
✓	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

palpable mass in the posterolateral aspect of the neck, ®, 0.5 and x0.5cm # 2, movable, tender.

® eye - medially deviated - see back. unsignificantly reactive to light ®.

regular rate & rhythm.

external hemorrhoid

good ROM.

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth (0) — Non-restorable teeth (/) — Missing Teeth (x) — Replaced by Dentures — Fixed Partial dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5'9	149	Black	Brown	[x] SLENDER [ ] MEDIUM [ ] HEAVY [ ] OBESE	98.8

57. BLOOD PRESSURE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (5 min.)
SYS. 120 / DIAS. 50	SYS. / DIAS.	SYS. / DIAS.

58. PULSE *(Arm at heart level)*

A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
62				

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 200 CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ 30 CORR. TO 20/	BY S. CX	CORR. TO BY

62. HETEROPHORIA *(Specify distance)*

ES*	EX*	R.H.	L.H.	PRISM DIV.	PRISM CONV.	PC	PD
					CT		

63. ACCOMMODATION RIGHT LEFT

64. COLOR VISION *(Test used and result)*: Ishihara's test passed

65. DEPTH PERCEPTION *(Test used and score)* UNCORRECTED CORRECTED

66. FIELD OF VISION

67. NIGHT VISION *(Test used and score)*

68. RED LENS TEST

69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV /15 SV /15

LEFT WV /15 SV /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT	✓	✓	✓	✓	N/A	✓	N/A	
LEFT	✓	✓	✓	✓	N/A	✓	N/A	

72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*

73 NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY**

- Denies H/O Hepatitis / Syphilis
- No suicidal ideation
- Denies IV drug use.
- Claims that he was boxing, right eye problem - denies (R) eye injury; Dx to have episcleritis 7/03. Reports palpable mass on the right side of neck x 1 yr, ⊘ increase in size, ⊘ tender.

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

- H/O Episcleritis (R) eye
- Error of Refraction
- Lymphadenopathy, (R) side neck.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

Surgery; Optometrist.

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

B. PHYSICAL CATEGORY

A	B	C	E

77. EXAMINEE *(Check)*

A. [ ] IS QUALIFIED FOR regular quarters/restricted duty

B. [ ] IS NOT QUALIFIED FOR

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN ...milton, MLP ... Petersburg, Va — SIGNATURE [signature]

80. TYPED OR PRINTED NAME OF PHYSICIAN Dr. K. Laybourn, Medical Officer — SIGNATURE [signature]

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* FCC Petersburg, Virginia — SIGNATURE

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME: Ward - Myron
2. GRADE AND C... ENT OR POSITION:
3. IDENTIFICATION NO.: 05967-084
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code):
5. PURPOSE OF EXAMINATION: FOOD HANDLERS' PHYSICAL
6. DATE OF EXAMINATION: 1-25-01
7. SEX: M
8. RACE: B
9. TOTAL YEARS GOVERNMENT SERVICE — MILITARY / CIVILIAN
10. AGENCY: FCI Lochy
11. ORGANIZATION UNIT: HSU
12. DATE OF BIRTH: 7/7/70
13. PLACE OF BIRTH
14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: FCI LORETTO
16. OTHER INFORMATION
17. RATING OR SPECIALTY
TIME IN THIS CAPACITY (Total) / LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
N/A	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

The following is a FOOD HANDLERS' PHYSICAL which determines if and inmate is medically cleared, free of infectious disease, and is able to work in Food Service. It determines if the inmate is free from: Acute or chronic inflammatory conditions of the respiratory system; Acute or chronic infectious skin diseases; Acute or chronic intestinal infection and/or communicable disease.

TMS intact
Legally Blind (R) eye
PERRLA
GUMS intact
CTA
RRR/M/G/R
Good Pulses No Varicosities
NABSX4 Quads No MTO

From Strength 5/5

From Strength 5/5

Abrasions, Nodes & Tattoos
Sensations intact of Extremities

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT

Restorable Teeth: 0 / 1 2 3 / 32 31 30 / 0
Non-restorable teeth: / 1 2 3 / 32 31 30 /
Missing Teeth: x / 1 2 3 / 32 31 30 / x
Replaced by Dentures: x x x / 1 2 3 / 32 31 30 / x x x
Fixed Partial dentures: (x) / 1 2 3 / 32 31 30 / (x)

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY
B. ALBUMIN
C. SUGAR
D. MICROSCOP...
46. CHEST X-RAY (F... date, film number and result)
47. SEROLOGY (Specify test used and result)
48. EKG
49. BLOOD TYPE AND ... FACTOR
50. OTHER TESTS

N/A

Standard Form 88 (Rev. 3-89)
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41CFR) 201-45.505

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56. TEMPERATURE

57. BLOOD PRESSURE (Arm at heart level)

A. SITTING	SYS. 115 DIAS. 80	B. RECUMBENT	SYS. DIAS.	C. STANDING (5 min.)	SYS. DIAS.

58. PULSE (Arm at heart level)

A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ Legally Blind CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ CORR. TO 20/	BY S. CX	CORR. TO BY

62. HETEROPHORIA (Specify direction)

ES*	EX*	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

N/A

63. ACCOMMODATION RIGHT	LEFT	64. COLOR VISION (Test used and results)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED / CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV /15 SV /15

LEFT WV /15 SV /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

PPD Status:

Date: 3-21-00 **Results:** 0mm

CXR: (If applicable)

Date: _____ **Results:** _____

RPR Status:

Date: 5-10-99 **Results:** NR

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

The patient is able to work in Food Service: Yes X **No** _____

The inmate received patient education and was advised to keep hands clean at all times while handling food, wear protective gloves when handling food, wash hands after using restroom and to report any suspicious rash or skin lesions, fever, night sweats or productive coughing to Health Services Staff. The patient voiced understanding of above instructions.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (Check)

A. ☑ IS QUALIFIED FOR FOOD SERVICE

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Latterner PA-S	Latterner PA-S
80. TYPED OR PRINTED NAME OF PHYSICIAN Tracy L. Tyger, PA-C Physician Assistant-Cert.	SIGNATURE Tracy L. Tyger PA-C
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 5/7/99

1. LAST NAME–FIRST NAME–MIDDLE NAME: Ward, Myron
2. IDENTIFICATION NUMBER: 05967-087
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): 12,207 Bushey Dr. #3, Wheaton, MD 20902
5. EMERGENCY CONTACT (Name and address of contact): May Daniels, 7686 Fountain Blue Dr., New Carrollton, MD 20784
6. DATE OF BIRTH: 7/1/70
7. AGE: 28
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: mother
10. PLACE OF BIRTH: Washington, D.C.
11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOP FCI Cumberland
12b. ORGANIZATION UNIT: Health Services
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: FCI CUMBERLAND
15. RATING OR SPECIALTY OF EXAMINER: RN
16. PURPOSE OF EXAMINATION: Intake physical

17. CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP	
✓	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	
✓	C. DRUMS (Perforation)	
✓	D. NOSE	
✓	E. SINUSES	
✓	F. MOUTH AND THROAT	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)	
✓	H. OPHTHALMOSCOPIC	
✓	I. PUPILS (Equality and reaction)	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	K. LUNGS AND CHEST	
✓	L. HEART (Thrust, size, rhythm, sounds)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)	
✓	N. ABDOMEN AND VISCERA (Include hernia)	
✓	O. GENITOURINARY SYSTEM, MALE	
NE	P. PROSTATE (Over 40 or clinically indicated)	
✓	P. TESTICULAR	
✓	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	R. ENDOCRINE SYSTEM	
✓	S. G-U SYSTEM	
✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	U. FEET	
✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	Y. SKIN, LYMPHATICS	
✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	AA. PSYCHIATRIC (Specify any personality deviation)	
✓	BB. BREASTS	
N/E	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

RIGHT																LEFT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Restorable Teeth: 0 (32, 31, 30) — Non-restorable teeth: / (32, 31, 30) — Missing Teeth: X (32, 31, 30) — Replaced by Dentures: X X X (32, 31, 30) — Fixed Partial Dentures: [X (32, 31, 30)]

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES:

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC
B. CHEST X-RAY OR PPD (Place, date, film number and result)
C. SYPHILIS SEROLOGY (Specify test used and results)
D. EKG
E. BLOOD TYPE AND RH FACTOR
F. OTHER TESTS

NSN 7540-00-634-4038
88-126

STANDARD FORM 88 (Rev. 10-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED
Ward, Myron	08967-084	

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5'10½"	167lb	black	brown	☒ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	97

26. BLOOD PRESSURE *(Arm at heart level)*

A. SITTING	SYS. 118 / DIAS. 76	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 mins.)	SYS. / DIAS.		

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
84				

28. DISTANT VISION	29. REFRACTION	30. NEAR VISION
RIGHT 20/ Legally blind CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY

31. HETEROPHORIA *(Specify distance)*

ESO EXO R.H. L.H. PRISM DIV. PRISM CONV. CT PC PD

32. ACCOMMODATION	33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT LEFT			CORRECTED
35. FIELD OF VISION	**36. NIGHT VISION** *(Test used and score)*	**37. RED LENS TEST**	**38. INTRAOCULAR TENSION**
RIGHT LEFT			RIGHT LEFT

39. HEARING

RIGHT W/V /15 S/V /15

LEFT W/V /15 S/V /15

40. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

HOSP Ø PSY HX Ø

ALLERGY Ø PMH Ø

DRUG HX See below PSH Ø

MEDICATION Ø ALCOHOL HX See below

OTHER: SPECIFY Ø

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

drug Hx → 12 yrs used PCP fairly heavily

alcohol → used heavily along with PCP

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A. ☒ IS QUALIFIED FOR Work

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF ~~PHYSICIAN~~ Clear nurse

Dawn Williams RN SIGNATURE Dawn Williams RN

49. TYPED OR PRINTED NAME OF PHYSICIAN HOWARD, MD SIGNATURE

CLINICAL DIRECTOR

FCI CUMBERLAND

50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* SIGNATURE

51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY SIGNATURE

*U.S. Government Printing Office: 1997 - 418-149/40131

U.S. Department of Justice
Federal Bureau of Prisons
Federal Detention Center
P.O. Box 572
Philadelphia, Pennsylvania 19105

It is important that the BOP screen each newly committed inmate for communicable diseases. Each inmate is required to answer the following questions:

1. Do you have a cough? (Yes/No): _____
If Yes;
- How long have you had this cough? about 1 yr
- Does anything come up with this cough? no
- Does your chest hurt with this cough? Sometimes

2. Have any of the following symptoms been present for at least three (3) weeks (circle yes or no)?
- fever Yes/No
- chills Yes/No
- night sweats Yes/No
- easy fatigability Yes/No
- loss in appetite Yes/No
- more than ten (10) pounds weight loss Yes/No

I certify that the above answers are correct

Myron Ward 10/21/03
Inmate Date

05967-084
Register Number

Es importante quel BOP examine a todos los reclusos y reclusas para las enfermedades contagiosas. Es requerido que cada reclusos y reclusas contesten las siguientes preguntas:

1. ¿Tiene usted tos? Si/No _____
Sí usted marca si
- ¿Cuánto tiempo ha tenido la tos? _____
- ¿Cuando tose algo sale con la tos? _____
- ¿Su pecho duele con la tos? _____

2. ¿Algunos de los siguientes sintomas han sido presentado en las últimas tres semanas (marca si o no)?
- fiebre Si/No
- escalofrío Si/No
- sudor de noche Si/No
- se cansa fácil Si/No
- pérdida de apetito Si/No
- ha perdido mas de diez libras Si/No

Yo certifico que mis respuestas arribas estan correctas

Reclusa/Recluso Fecha

Numero de Registro

U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HIST REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME

B/M/O/07-07-1970 REGISTER NUMBER
HT/509 WT/155 HR/BK EY/BN
CUSTODY/IN

3. PURPOSE OF EXAMINATION

4. DAT

FCC Pem

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND I

nt arises)

WARD
MYRON ARVEL 05967-084
B/M/O/07-07-1970
HT/509 WT/155 HR/BK EY/BN
CUSTODY/IN

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	X	Wear glasses or contact lenses
	X	Have vision in both eyes legally blind Beyer
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever		X		Adverse reaction to serum drug		X		Epilepsy or fits
	X		Rheumatic fever		X		or medicine		X		Car, train, sea or air sickness
	X		Swollen or painful joints		X		Broken bones		X		Frequent trouble sleeping
	X		Frequent or severe headache		X		Tumor, growth, cyst, cancer		X		Depression or excessive worry
X			Dizziness or fainting spells		X		Rupture/hernia		X		Loss of memory or amnesia
X			Eye trouble		X		Piles or rectal disease		X		Nervous trouble of any sort
X			Ear, nose, or throat trouble		X		Frequent or painful urination		X		Periods of unconsciousness
	X		Hearing loss		X		Bed wetting since age 12		X		Have you ever had
	X		Chronic or frequent colds		X		Kidney stone or blood in urine		X		homosexual contact?
	X		Severe tooth or gum trouble		X		Sugar or albumin in urine		X		Been exposed to AIDS
X			Sinusitis		X		VD—Syphilis, gonorrhea, etc.		X		Alcohol Use (Excessive)
	X		Hay Fever		X		Recent gain or loss of weight		X		Drug Use/Addiction
	X		Head injury		X		Arthritis, Rheumatism, or Bursitis		X		Marijuana
	X		Skin diseases		X		Bone, joint or other deformity		X		Cocaine
	X		Thyroid trouble		X		Lameness		X		Heroin
	X		Tuberculosis		X		Loss of finger or toe		X		L.S.D.
	X		Asthma		X		Painful or "Trick"shoulder or elbow		X		Amphetamines
X			Shortness of breath		X		Recurrent back pain		X		Others: (Specify)
	X		Pain or pressure in chest		X		"Trick" or locked knee		X		
X			Chronic cough		X		Foot trouble		X		Alcohol or drug
	X		Palpitation or pounding heart		X		Neuritis		X		Withdrawal Problems
	X		Heart trouble		X		Paralysis (include infantile)		X		
	X		High or low blood pressure								
	X		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	X		Frequent indigestion						X		Been treated for a female disorder
	X		Stomach, liver, or intestinal trouble						X		Had a change in menstrual pattern
	X		Gall bladder trouble or gallstones						X		ARE YOU PREGNANT
	X		Jaundice or hepatitis						X		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

Clerical Work

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		D. Other medical reasons *(If yes, give reasons.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13-22 ABOVE)

Ø hospitalization

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE Myron Ward

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___

OTHER Bus.

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? Denies

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? N/A

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___ NOT fully work

GENERAL POPULATION ✓ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___ N/A

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

1. legally blind to Rt eye – since birth
2. sinusitis.
3. sinus. } steroid nose spray.
4. "coughs alot" – from sinus drainage.
5. Chronic – sinus drainage.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
L. Casuccio, R.N.	10/22/03	Casuccio RN	

REVERSE

U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HIS[illegible]Y REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
WARD, MYRON	05967-084

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
A+O	10/20/03	Health Services Unit FDC Philadelphia

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

"FAIR"

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
X		Wear glasses or contact lenses
	X	Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever		X		Adverse reaction to serum drug or medicine		X		Epilepsy or fits
	X		Rheumatic fever						X		Car, train, sea or air sickness
	X		Swollen or painful joints		X		Broken bones		X		Frequent trouble sleeping
	X		Frequent or severe headache		X		Tumor, growth, cyst, cancer		X		Depression or excessive worry
	X		Dizziness or fainting spells		X		Rupture/hernia		X		Loss of memory or amnesia
X			Eye trouble		X		Piles or rectal disease		X		Nervous trouble of any sort
X			Ear, nose, or throat trouble		X		Frequent or painful urination		X		Periods of unconsciousness
	X		Hearing loss		X		Bed wetting since age 12		X		Have you ever had homosexual contact?
	X		Chronic or frequent colds		X		Kidney stone or blood in urine				
	X		Severe tooth or gum trouble		X		Sugar or albumin in urine		X		Been exposed to AIDS
X			Sinusitis		X		VD—Syphilis, gonorrhea, etc.		X		Alcohol Use (Excessive)
	X		Hay Fever		X		Recent gain or loss of weight		X		Drug Use/Addiction
	X		Head injury		X		Arthritis, Rheumatism, or Bursitis		X		Marijuana
	X		Skin diseases		X		Bone, joint or other deformity		X		Cocaine
	X		Thyroid trouble		X		Lameness		X		Heroin
	X		Tuberculosis		X		Loss of finger or toe		X		L.S.D.
	X		Asthma		X		Painful or "Trick"shoulder or elbow		X		Amphetamines
X			Shortness of breath		X		Recurrent back pain				Others: (Specify)
			Pain or pressure in chest		X		"Trick" or locked knee				
X			Chronic cough		X		Foot trouble				
	X		Palpitation or pounding heart		X		Neuritis		X		Alcohol or drug Withdrawal Problems
	X		Heart trouble		X		Paralysis (include infantile)				
	X		High or low blood pressure								
	X		Cramps in your legs								
	X		Frequent indigestion								
	X		Stomach, liver, or intestinal trouble								
	X		Gall bladder trouble or gallstones								
	X		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☒ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	X	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		X	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	X	B. Inability to perform certain motions.		X	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	X	C. Inability to assume certain positions.		X	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		D. Other medical reasons *(If yes, give reasons.)*		X	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	X	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	X	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	X	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Myron Ward

SIGNATURE: Myron Ward

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

1) Legally blind (R) eye -
2) HX: Pneumothorax
3) Occasional SOB & nighttime cough.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE

MYRON MARVEL 57-084
B/M/O/07-07-1970
HT/510 WT/150 HR/BN EY/BK
CUSTODY/TN

MEDICAL HISTORY REPORT

) MEDICALLY CONFIDENTIAL USE ONLY
TO UNAUTHORIZED PERSONS)

2. REGISTER NUMBER: 05967-084

.TION

5. EXAMINING FACILITY: FCI CUMBERLAND

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	X	Wear glasses or contact lenses
	X	Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever
	X		Rheumatic fever
	X		Swollen or painful joints
	X		Frequent or severe headache
	X		Dizziness or fainting spells
X			Eye trouble
	X		Ear, nose, or throat trouble
	X		Hearing loss
	X		Chronic or frequent colds
	X		Severe tooth or gum trouble
	X		Sinusitis
	X		Hay Fever
	X		Head injury
	X		Skin diseases
	X		Thyroid trouble
	X		Tuberculosis
	X		Asthma
	X		Shortness of breath
	X		Pain or pressure in chest
	X		Chronic cough
	X		Palpitation or pounding heart
	X		Heart trouble
	X		High or low blood pressure
	X		Cramps in your legs
	X		Frequent indigestion
	X		Stomach, liver, or intestinal trouble
	X		Gall bladder trouble or gallstones
	X		Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
	X		Adverse reaction to serum drug or medicine
	X		Broken bones
	X		Tumor, growth, cyst, cancer
	X		Rupture/hernia
	X		Piles or rectal disease
	X		Frequent or painful urination
	X		Bed wetting since age 12
	X		Kidney stone or blood in urine
	X		Sugar or albumin in urine
	X		VD—Syphilis, gonorrhea, etc.
	X		Recent gain or loss of weight
	X		Arthritis, Rheumatism, or Bursitis
	X		Bone, joint or other deformity
	X		Lameness
	X		Loss of finger or toe
	X		Painful or "Trick"shoulder or elbow
	X		Recurrent back pain
	X		"Trick" or locked knee
	X		Foot trouble
	X		Neuritis
	X		Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
	X		Epilepsy or fits
	X		Car, train, sea or air sickness
	X		Frequent trouble sleeping
	X		Depression or excessive worry
	X		Loss of memory or amnesia
	X		Nervous trouble of any sort
	X		Periods of unconsciousness
	X		Have you ever had homosexual contact?
	X		Been exposed to AIDS
X			Alcohol Use (Excessive)
X			Drug Use/Addiction
			Marijuana
			Cocaine
			Heroin
			L.S.D.
			Amphetamines
			Others: (Specify)
X			PCP
			Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?
Clerk typist

12. ARE YOU (Check one)
☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	X	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		X	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	X	B. Inability to perform certain motions.		X	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	X	C. Inability to assume certain positions.			
	X	D. Other medical reasons *(If yes, give reasons.)*		X	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	X	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		X	21. Have you ever been discharged from military service because of physical, mental, of other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	X	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	X	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	X	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: WARD, MYRON

SIGNATURE: Myron Ward

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? N

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ✓ RESTRICTED ____

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

Have you ever been exposed to TB No
Hepatitis No Syphilis No AIDS No
Homosexual Activity No Seizures No
Asthma No Any current meds Ye
Any drug allergies No
Sick call explained Ye
Pill line explained

Celexa 10mg BID # 30

TYPED OR PRINTED NAME OF EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
MELL JEANRONGO, PA ECI CUMBERLAND	4/21/99		

REVERSE

BP-S360.060 MEDICAL HIST(EPORT CDFRM MAY 1994

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
WARD, Myron - ARVeL	
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION**	**5. EXAMINING FACILITY**
Intake Screening	4-5-99	**Federal Transfer Center, Oklahoma City, OK**

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

7. HAVE YOU EVER **(Please check each item)**

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
	X	Wear glasses or contact lenses
	X	Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever		X		Adverse reaction to		X		Epilepsy or fits
	X		Rheumatic fever		X		drug or medicine				Car,train,sea or air sickness
	X		Swollen or painful		X		Broken bones		X		Frequent trouble sleeping
	X		joints		X		Tumor,growth,cyst,cancer		X		Depression or excessive worry
			Frequent or severe		X		Rupture/hernia		X		Loss if memory or amnesia
X			headache		X		Piles or rectal disease		X		Nervous trouble of any sort
	X		Dizziness or fainting				Frequent or		X		Periods of unconsciousness
	X		spells		X		painful urination		X		Have you ever had
X			Eye trouble		X		Bed wetting since age 12		X		homosexual contact?
	X		Ear,nose,throat trouble		X		Kidney stone or		X		Been exposed to AIDS
	X		Hearing loss		X		blood in urine		X		Alcohol Use (Excessive)
	X		Chronic, frequent colds		X		Sugar, albumin in urine	X	X		Drug Use/Addiction
	X		Sever tooth, gum trouble	X			VD-Syphilis, gonorrhea,		X		Marijuana
	X		Sinusitis				etc.		X		Cocaine
	X		Hay Fever		X		Recent gain or loss of		X		Heroin
	X		Head injury		X		weight		X		L.S.D.
	X		Skin diseases		X		Arthritis, Rheumatism,		X		Amphetamines
	X		Thyroid trouble		X		or Bursitis		X		Others: (Specify)
	X		Tuberculosis		X		Bone, joint or		X		PCP
	X		Asthma		X		other deformity		X		Alcohol or drug
	X		Shortness of breath		X		Lameness		X		Withdrawal Problems

(This form may be replicated via WP)

This form replaces BP-360(60) dated January 1986.

X		Pain, pressure in chest	X		Loss of finger or toe				
X		Chronic cough	X		Painful or "Trick"				
X		Palpitation or pounding	X		shoulder or elbow	10. FEMALES ONLY	HAVE YOU EVER		
X		heart	X		Recurrent back pain				Been treated for a
X		Heart trouble		X	"Trick" or locked knee				female disorder
X		High or low blood		X	Foot trouble				Had a change in
X		pressure		X	Neuritis				menstrual pattern
X		Cramps in your legs		X	Paralysis (include				ARE YOU PREGNANT
X		Frequent indigestion		X	infantile)				SUSPECT YOU ARE PREGNANT
X		Stomach, liver, or		X	Gall bladder trouble or				
X		intestinal trouble		X	gallstones				
X		Jaundice or hepatitis							

11. WHAT IS YOUR USUAL OCCUPATION? Clerk Typist

12. ARE YOU (check one) ☒ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	X	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		X	18. Have you ever had any illness or injury noted? (If yes, specify when, where, and give details.)
	X	B. Inability to perform certain motions.		X	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	X	C. Inability to assume certain positions.			
	X	D. Other medical reasons (If yes, give reasons.)			
	X	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).		X	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	X	15. Have you ever been denied life insurance? reason and give details.)		X	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
X		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) Eye sight Age 17			
	X	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE VVARD, Myron | SIGNATURE Myron Ward

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___ OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS. PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO X

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___
GENERAL POPULATION ___ YES ___ NO
TYPE AND EXTENT OF LIMITATION ___

23. PHYSICIAN'S summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Todd Gander Clinical Nurse FCI Oklahoma City, OK	APR 05 1999		

Food or Drug Allergies: NKA; Allergies: ___
Current Medical Status: No Complaints: Complaint of ___
TB Signs and Symptom(s): NONE; cough, hemoptysis, night sweats, wt.los

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCC Petersburg Low	10/24/03	10:30

Inmate's Name	Register Number
Ward, Myron	05960-084

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
F Bailey	10/24/03	1:05 pm

Medical Staff Title RN F. Bailey, RN, PHS

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

PRINTED ON RECYCLED PAPER

WARD
MYRON ARVEL 05967-084
B/M/O/07-07-1970
HT/509 WT/155 HR/BK EY/BN
CUSTODY/IN

Pat

FEDERAL BUREAU OF PRISONS

FCC Pem

ening form on all arrivals to the

crival	Time of Arrival
10/22/03	1430

WARD
MYRON ARVEL 05967-084

Register Number

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
Carucciors	10/22/03	1730

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

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BP-S354.060 **INTAKE SCREENI... IEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FDC Phila.	10/20/03	1600

Inmate's Name	Register Number
Ward, Myron	05967-084

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

NO F/S.

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS) Code(s)

6. Remarks: ☒ Medications ☒ Allergies ☒ Lice ☒ Suicidal Ideation

Medical Staff Signature	Date	Time
Maren NP-C	10/20/03	1815

Medical Staff Title NP-C.

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

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BP-S354.060 NOV 94 **INTAKE SCREENING (MEDICAL)** CDFRM

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
U.S.P.LEWISBURG,PA	**OCTOBER 17,2003**	**1300**

Inmate's Name	Register Number
WARD , MYRON	**05967 - 084**

M E D I C A L C L E A R E N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
	OCTOBER 17,2003	**1415 HRS.**

Medical Staff Title **FERDINAND N. ALAMA,P.A.**

Record Copy - Inmate Central File; copy - file

(This form may be replicated via WP) Replace BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENI (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
MCKean	7/20/01	0930

Inmate's Name	Register Number
Ward, Myron	05967-084

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: Blind (R) eye

Medical Staff Signature	Date	Time
Clundberg	7/20/01	1245

Medical Staff Title
Cheryl Lundberg, RN

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94

12

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP LEWISBURG Health Services Unit Lewisburg, PA 17837	7/13/01	1815

Inmate's Name	Register Number
Ward, Myron Arvel	05967-084

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☑ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
MLP	7/13/01	1855

Medical Staff Title

Jane Okoth, MLP

Jane Okoth, MLP

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

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BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCI Loretto	1/5/01	

Inmate's Name	Register Number
WARD, MYRON	05967-084

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)
PENDING

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)
NA

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
	1-3-01	1411

Medical Staff Title
PA-C

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCREENI** ; **(MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Ins	WARD MYRON ARVEL Ø5967-Ø84 B/M/O/Ø7-Ø7-197Ø	Arrival	Time of Arrival 1945
Inm	HT/51Ø WT/15Ø HR/BN EY/BK CUSTODY/IN	Register Number	

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date 1-2-01	Time 2158
Medical Staff Title RN		

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

D

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCI Cumberland	4-26-99	1630

Inmate's Name	Register Number
Ward, Myron	05967-084

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☐ yes; ☒ no (Explain)

   J+C

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

   No F/S

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☐ no (If yes, enter code(s) into MDS)
   Code(s)

6. Remarks:

   SCREENED FOR LICE
   ESSENTIALLY HEALTHY MALE

Medical Staff Signature	Date	Time
	4-26-99	1750

Medical Staff Title Richard Klimkiewicz, PA-C
FCI CUMBERLAND

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

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BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE [redacted] **FEDERAL BUREAU OF PRISONS**

WARD
MYRON ARVEL 05967-084
B/M/O/07-07-1970
HT/510 WT/150 HR/BN EY/BK
CUSTODY/IN

(Medical staff shall complete t[redacted]le
Institution)

Institution | I

Inmate's Name

M E D I C

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature | Date APR 05 1999 | Time 1635

Medical Staff Title
Todd Genzer
Clinical Nurse
FTC, Oklahoma City, OK

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BILL TO: FCI PETERSBURG, BUS. OFF
PO# 0400060384
1060 RIVER RD.
HOPEWELL,
VA, 23860

OPT A 11

PATIENT NAME: 05967-084 LI-56 111754
CUST. NUMBER: PO: 0400060384
INVOICE NUMBER: 193593
Tray No.: 8781
Date Processed: 06/10/2004
06/24/2004

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	0.50				6.00
L. EYE	0.50				6.00

	Add	Width	Height
R. EYE			0.0
L. EYE			0.0

R. EYE 64.0
L. EYE P.D. 64.0 N.P.D.

FRAME DATA

Size	Depth	E.D.	D.B.L.
50.0	43.0	50.0	22.0

Model: 032027167435 BPL. Length 50 50X22
83-84 SMOKE

EDGED UNCUT [X] [ ] LENS ONLY [ ] ENCLOSED [ ] TO COME [ ] SUPPLIED [X]

LENS DATA

	Type	Material
R:	SV CR-39 SRC1	SOLA 72
L:	SV CR-39 SRC1	SOLA 72

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

CHARGES

DESCRIPTION	PRICE
RIGHT LENS	11.00
LEFT LENS	11.00
83-84	12.00
SAFETY	.00
Sub Total	34.00
Freight	
Total Due	34.00

COMMENTS:
J-10226530 LI-56 T-8781

OPT A 20

FROM: 111754
3593
POSTMASTER
IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER

SHIP TO:
FCI PETERSBURG, HEALTH SVC
PO# BOP04000602834
1060 RIVER RD.
HOPEWELL, VA, 23860

OPT A 11

PATIENT NAME: 05967-084 LI-55 111754
CUST. NUMBER: P0: 0400060384
INVOICE NUMBER: 193591
Tray No.: 9849
Date Processed: 06/10/2004
06/24/2004

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	0.00	-0.25	180		6.25
L. EYE	0.00	-0.25	180		6.25

	Add	Width	Height
R. EYE		0.0	
L. EYE			0.0

	P.D.	N.P.D.
R. EYE	68.0	
L. EYE	68.0	

FRAME DATA

Size	Depth	E.D.	D.B.L.
50.0	43.0	50.0	22.0

Model: 83-84
032027167430 PL. Lens 50 50X22 SMOKE

EDGED UNCUT [X] [ ] LENS ONLY [ ] ENCLOSED [ ] TO COME [ ] SUPPLIED [X]

LENS DATA

	Type	Material
R:	SV POLY	QNTMGY VISION 75
L:	SV POLY	QNTMGY VISION 75

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

CHARGES

DESCRIPTION	PRICE
RIGHT LENS	46
LEFT LENS	46
83-84	12
SAFETY	
Sub Total	104
Freight	
Total Due	104.

COMMENTS:
J-10226530 LI-55 T-9849

POSTMASTER: IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER

SHIP TO:
FCI PETERSBURG, HEALTH SVC
PO# BOP04000602834
1060 RIVER RD.
HOPEWELL, VA. 23860

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Surgery

FROM: (Requesting physician or activity) Dr. Laybourn M.D.

DATE OF REQUEST 5-20-04

REASON FOR REQUEST (Complaints and findings)

33 y.o male with history of biletateral cervical lymph nodes and axillary lymp nodes. He underwent lymph node biopsia + r/o lymphoma on 5-20-04

PROVISIONAL DIAGNOSIS

R/O Lymphoma / S/P Lymph node biopsies

DOCTOR'S SIGNATURE

V. Logan RN

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

Next visit

S/P Rt neck lymph node BX
Non specific lymphadenitis. Nomalignancy
wound healed well
Future removal.
path report discussed c pt

Concur
KLM
6/10/04

(Continue on reverse side)

SIGNATURE AND TITLE K.A. Laybourn, M.D. DATE 6/9/04

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Ward, Myron
05967-084

F.C.I. Petersburg
Health Services Unit
Petersburg, VA 23804

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: ENT. | FROM: (Requesting physician or activity) [illegible] | DATE OF REQUEST 2/10/04

REASON FOR REQUEST (Complaints and findings)

33 YO blk c/o bilat rhinitis and nasal congestion for more than one year. Has tried Vanceril, Actifed, Chlorpheniramine and nasalide without good results.

please evaluate

PROVISIONAL DIAGNOSIS

Chronic sinusitis. NO nasal polyps

DOCTOR'S SIGNATURE
A. Zavas, P.A.
FCI Petersburg, VA

APPROVED 10/10/04

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

CC: Stuffed-up, sneezing around nose XT 1YR
different Med. doesnot work

PE: ENT-Head & Neck Ex.
MMT turbinate

Dx: Chr. turbinate dysfuction
Rhinits

Rec: Saline nose spry daily hs
Humibid DLA ÷ BID. X 10dys

Concur
PRO
3/12/04
K.A. Laybourn, M.D.

(Continue on reverse side)

SIGNATURE AND TITLE [signature] DATE 3/10/04

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Ward, Keyon
05967-084

Rec Petersburg dm

Health Services Unit-Low
FCC Petersburg, Virginia

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-110 NSN 7540-00-634-4127

0242

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

: general surgery: Dr Rayudu	FROM: (Requesting physician or activity) Laybourn	DATE 1-20-2004

REASON FOR REQUEST (Complaints and findings)

33 yo male with h/o bilateral cervical lymph nodes and axillary lymph nodes. He was evaluated by general surgeon who recommended that lymph node biopsies be performed to r/o lymphoma.

PROVISIONAL DIAGNOSIS

Cervical lymphadenopathy

DOCTOR'S SIGNATURE	APPROVED	
C. K. Laybourn, M.D. Medical Officer U.S. Petersburg, Virginia	Dr. J. Allen Clinical Director FCC Petersburg	_____ ROUTINE _____ ASAP __X__ 1 MONTH _____ 2-3 WEEKS _____ OTHER

CONSULTATION REPORT

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical fac

NAME: Ward, Myron #05967-084

DATE OF BIRTH: 07-07-1970

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

DOB 07-07-70
R/S Blm
Unit L-3
Level In
Faxed 1-22-04

13-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Surgery | FROM: (Requesting physician or activity) Medical | DATE OF REQUEST 12/30/03

REASON FOR REQUEST (Complaints and findings)

33y WBM who reports palpable mass on the right side of the neck x 1yr. No increase in size. Tender about 0.5 cm x 0.5cm, mobile in the posterior cervical triangle of neck (R).

PROVISIONAL DIAGNOSIS

Lymphadenopathy, R neck

DOCTOR'S SIGNATURE [illegible] | APPROVED [illegible] | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☒ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

Copies [illegible] 1-14-04

Dr. K Laykoum, M.D.
Medical Officer
FCC Petersburg, Virginia

c/o lumps in neck x 1yr
no fever.
O/E: Bilateral cervical lymphadenopathy
nontender. no bruits no thyroid enlargement.
? Axillary lymphadenopathy also palpable
no Hepatosplenomegaly
Recommend: Cervical lymph node Bx
R/o lymphoma

(Continue on reverse side)

SIGNATURE AND TITLE [signature] | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)

Ward, Myra
359670847
FCC Pet-Lee

REGISTER NO. | WARD NO.

7-7-70
7-10

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

Department of Justice
Federal Bureau of Prisons
FCI - Petersburg
Petersburg, Virginia

UTILIZATION REVIEW CHECKLIST

Name: Ward, Myron	Reg #: 03967-094	Date: 1-20-04
Diagnosis/Impression	Lymphadenopathy	
How long has the condition existed?	Tyr	
Describe Prior evaluation and treatment.	sick call gen surgery	
Degree of disability	mild	
Release date	7-10-18	
Compliance with prior treatment		
Other comments		

☑ Approved ☐ Disapproved

Dr. J. Allen
Clinical Director
FCC Petersburg
C. D.

1/21/04
Date

C. Mendoza 1/21/04
H. S. A.

C. Mendoza
Health Services Administrator

A. W. O.

1/21/04

Reason for action:

Please attach completed UR Checklist to: **Consultation Sheet (SF-513)**

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Surgery | FROM: (Requesting physician or activity) Medical | DATE OF REQUEST 12/30/03

REASON FOR REQUEST (Complaints and findings)

33y WM who reports palpable mass on the right side of the neck x1yr. No increase in size tender, about 0.5 cm x 0.5cm, mobile in the posterior cervical aspect of neck (R).

PROVISIONAL DIAGNOSIS

Lymphadenopathy, (R) neck

DOCTOR'S SIGNATURE E. Panagiotou, MD FCC Petersburg, Va | APPROVED yes | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☒ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

Hx lumps in neck x 1yr
no fever.
OE: Bilateral cervical lymphadenopathy
nontender. no bruits no thyroid enlargement.
? Axillary lymphadenopathy also palpable
no Hepatosplenomegaly
Recommend: Cervical lymph node Bx
R/o lymphoma

Cancel per 1-14-04
Dr. K Laybourn, M.D.
Medical Officer
FCC Petersburg, Virginia

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Ward, Myron
059-67-0837
FCC Pet Lom

FCC Petersburg, Virginia

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

REQUEST

TO: Optometrist - Dr. Howard

FROM: (Requesting physician or activity) Dennis Olson, MD, CHP

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

Eye Exam Epiescleritis

Subjective:

PROVISIONAL DIAGNOSIS

PHYSICIAN'S SIGNATURE: Dennis Olson MD

D. Olson, MD
Clinical Director

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY
☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD OS

Near OD OS

TONOMETRY: OD OS

External

Internal

Refraction

Diagnosis episcleritis 100% gone

Analysis topex predforte as directed

Plan tid for 3 days
bid for 3 days
hs for 3 days
PRN

(Continue on reverse side)

SIGNATURE AND TITLE: Christian J. Howard OD

DATE: 6/18/03

IDENTIFICATION NO.

ORGANIZATION: FCI/FPC McKean

FCI McKean (Medical Facility)

REGISTER NO. 05967-054

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries: name—last, first)

Ward, Myron

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 7-91)
Prescribed by GSA/ICMP

Reviewed by D. Olson, MD
Date: 6/18/03

REQUEST

TO: Optometrist - Dr. Howard

FROM: (Requesting physician or activity) Dennis Olson, MD, CHP

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

Eye Exam

Subjective:

(R) conjunctivitis since a kid

PROVISIONAL DIAGNOSIS

PHYSICIAN'S SIGNATURE Dennis Olson MD

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

D. Olson, MD Clinical Director

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD OS 20/20

Near OD OS .37m

TONOMETRY: OD 16 OS 17 Goldmann 0943

External WNL (O)

Internal deep redness deep vessels

Refraction tender to touch

Diagnosis Episcleritis

Analysis requires steroid antibiotics

Plan recommend Pred Forte gtt OU for 1 week, then tid for 3 days bid for 3 days hs for 3 days

(Continue on reverse side)

SIGNATURE AND TITLE Christine J. Howard OD

DATE 6/11/03

IDENTIFICATION NO. ORGANIZATION FCI/FPC McKean REGISTER NO. FCI McKean WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries: name—last, first, middle initial) (Medical facility)

CONSULTATION SHEET

Medical Record

Ward, Myron

Reviewed by D. Olson, MD

Date 6/11/03

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: Optometry

FROM: (Requesting physician or activity) Dr. Howard / PA Klingensmith

DATE OF REQUEST 5-25-99

REASON FOR REQUEST (Complaints and findings)

PT legally blind in R eye from birth c/o problem c L eye vision - sees spots / occasional blurring, has been reading a lot

PROVISIONAL DIAGNOSIS

Eye Strain

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

no show for Appt 6-9-99 0730 Age 29

Reschedule 5/16/00

(R) Amblyopia (did patching as child)

- Eyes red. and itching etc.

SLE: conj ch
lens ch
Ant leuc

Acuity 20/20

T 16
16

Funds: Clear CD. 2

Ref: Plano
Myn 3 +50 FND

(Continue on reverse side)

SIGNATURE AND TITLE Robert A. Howard DATE 5-10-00

IDENTIFICATION NO. | ORGANIZATION | REGISTER NO. | WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Ward, Myron
05967-084

S. HOWARD, MD
CLINICAL DIRECTOR
FCI, CUMBERLAND

Rec'd 5/16/00

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
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MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Optometrist

FROM: (Requesting physician or activity) medical

DATE OF REQUEST 12/3/03

REASON FOR REQUEST (Complaints and findings)

33 y/o BM who was seen on routine PE & found to have ↓ vision OD = 20/200 OS = 20/30
pls. evaluate & thank you

PROVISIONAL DIAGNOSIS

Error of refraction

DOCTOR'S SIGNATURE E. Panegiton, MD FCC Petersburg, Va

APPROVED [signature]

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☒ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

PERRLA
APD ⊖
CT Ⓡ ET
FTFC OU

c/o No complaints
POHx Amblyopia Ⓡ eye Had patch Tx as child to strengthen, but no improvement
PMHx Sinusitis.
FOHx Ø FMH. Ø

T/A < 14 / 13

SLE
LL wnl
Conj Inj ⊖
K Cl
AC D+Q
Iris wnl
Lens Cl

CD .3/3
Mac ⊕ FLR

Ret OD -20.00
OS PL

DEE Tropic
⊖ R/T/B

Ⓐ post. staphyloma OD emetrope OS
Near Point Fatigue

Ⓟ Protective ℞ c̄ Transition and reading ℞

(Continue on reverse side)

SIGNATURE AND TITLE [signature]

DATE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR

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SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)

REGISTER NO.

WARD NO.

Ward, Myron
05967-084
FCC Pet Low

Concur
KAMD
5/12/04
K. A. Laybourn, M.D.

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

Eyeglass Prescription

WARD
05967-084

TRAY NO.	ARRIVAL DATE		PRESCRIPTION NO.

INSTITUTION:

CITY

STATE ZIP

LENSES			
EXTRA			
FRAME OR MTG			
MISC			

		SPHERE	CYLINDER	AXIS	PRISM	DIRECTION	IN	DEC	OUT
DISTANCE	R	+50	SPH			PNO			
	L	+50							
ADD	R								
	L								

SEGMENT INSTRUCTIONS

HEIGHT	WIDTH	INSET	PUPILLARY WIDTH DIST.	PUPILLARY WIDTH NEAR
R		R R	64	61
L		L L		

SEG. STYLE

ORTH. F TILLER D	EXECUTIVE TYPE	KRYPTOK	PANOPTIK	CURVED TOP	TRIFOCAL AND TYPE	STRAIGHT TOP	OTHER.
22		22	22-24	22-25		22 28 45 25 35	

FRAME OR SHAPE		EYE SIZE	BRIDGE SIZE	TEMPLE LENGTH AND STYLE
#29		50	22	5 1/2

Mail to:
Federal Prison Industries
Box 100
Butner, N.C. 27509

SPECIAL INSTRUCTIONS
( ) LENS ONLY
( ) FRAMES ONLY

Robert R Thrift 5-10-00

SIGNATURE DATE

USP LVN

Previous editions not usable

BP-357(60)
MAY 1984

South Side Regional Medical Center
501 South Adams Street
Petersburg, VA 23803

EC

~~05671-84~~ OV

05967-084

OPERATIVE REPORT

Name:	**WARD, MYRON A**				
Room:	O-SOP	DOB:	07/07/1970	Adm Dr:	RAYUDU, JUJJAVARAPU
MR#:	511619	Age:	33 Y	Ord Dr:	
Pt#:	6621654	Sex:	M	Dict:	05/20/2004 13:09:04
Adm:	05/20/2004	Disch:	05/20/2004	Trans:	05/20/2004 14:36:49

****Finalized Upon Physician Signature****

DATE OF OPERATION: 05/20/2004

PREOPERATIVE DIAGNOSIS: Cervical lymphadenopathy.

POSTOPERATIVE DIAGNOSIS: Cervical lymphadenopathy especially in the posterior triangle of the neck on the right side.

PROCEDURE PERFORMED: Lymph node biopsy from the posterior triangle of the right side of the neck.

SURGEON: JUJJAVARAPU RAYUDU, MD

ANESTHESIA: Local, 1% Lidocaine, 0.5% Marcaine, 1/2 and 1/2 combination prepared.

PLACE PERFORMED: Operating room.

HISTORY: This 33-year-old male presented with slightly enlarged lymph nodes along the posterior aspect of the neck, especially the right side. There is no evidence of any infection in the scalp or any areas of the head and neck. He is scheduled for a biopsy of this cervical lymph node.

PROCEDURE: The patient was placed supine on the table. The head was slightly elevated. Local

K.A. Laybourn, M.D.

(Continued on next page.)

KAL 5/25/04

South's Regional Medical Center
[illegible]01 South Adams Street
Petersburg, VA 23803

OPERATIVE REPORT

Name:	**WARD, MYRON A**				
Room:	O-SOP	DOB:	07/07/1970	Adm Dr:	RAYUDU, JUJJAVARAPU
MR#:	511619	Age:	33 Y	Ord Dr:	
Pt#:	6621654	Sex:	M	Dict:	05/20/2004 13:09:04
Adm:	05/20/2004	Disch:	05/20/2004	Trans:	05/20/2004 14:36:49

****Finalized Upon Physician Signature****

anesthesia was infiltrated in the skin and subcutaneous tissues along the posterior aspect of the right side of the neck over the palpable lymph node. The transverse incision was given along this area. The platysmas muscle was incised along the line of the skin incision. The skin incision was made about 1-inch in length. After opening the platysmas muscle, the dissection was continued along the posterior aspect. The trapezius muscle was identified. It was careful preserved. There is a lymph node, which is visible and very close to this nerve. It is carefully preserved, and the lymph node is dissected from this structure carefully. The specimen was sent for histopathological examination. Hemostasis was completely secured. The platysmas was approximated with 4-0 Monocryl continuous suture. The skin was closed with 4-0 Monocryl subcuticular continuous suture. Dry foam dressing was applied. The patient tolerated the procedure well. Transferred to the recovery room in satisfactory condition.

81503179 / 96531

cc: DR ALLEN AT FCI LOW PRISON

Dictated By: JUJJAVARAPU RAYUDU MD/TRA
Transcribed by TRA, 05/20/2004 14:36:49

Signed: _____